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8	BEFORE THE BOARD OF REGISTERED NURSING		
9	DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA		
10	2010-244		
11	In the Matter of the Accusation Against: Case No. 2010 - 244		
12	KRISTEN NOEL VOELKER 1105 Sepulveda Blvd., C-103		
13	Torrance, CA 90502 ACCUSATION		
14	Registered Nurse License No. 611593		
15	Respondent.		
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17	Complainant alleges:		
18	<u>PARTIES</u>		
19	1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her		
20	official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board),		
21	Department of Consumer Affairs.		
22	2. On or about January 9, 2003, the Board of Registered Nursing issued Registered		
23	Nurse License Number 611593 to Kristen Noel Voelker (Respondent). The Registered Nurse		
24	License was in full force and effect at all times relevant to the charges brought herein and will		
25	expire on October 31, 2010, unless renewed.		
26	JURISDICTION		
27	3. This Accusation is brought before the Board under the authority of the following		
28	laws. All section references are to the Business and Professions Code unless otherwise indicated.		
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STATUTORY PROVISIONS

- 4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.
 - 6. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- "(a) Unprofessional conduct, which includes, but is not limited to, the following:
- "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."
 - 7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

- "(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
- "(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
- "(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
- "(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.
- "(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.
- "(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY PROVISION

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

 DRUG DEFINITION

11. Heparin Flush IV is an anticoagulant used to keep intravenous (IV) catheters open and flowing freely. Heparin helps to keep blood flowing smoothly and from clotting in the catheter by making an anti-clotting protein in the body work better.

SUMMARY OF FACTS

- 12. Since about February 2003, Respondent was employed as a registered nurse in the Pediatrics Unit (4NE) at Cedars-Sinai Medical Center (CSMC), Los Angeles. On or about November 18, 2007, while working as the Charge Nurse at 4NE, Respondent duties included overseeing and assisting other nurses in the unit with their patient load. Respondent's shift was from 7 p.m. to 7 a.m. On November 18, 2007, Patient #1 and Patient #2, twins, were housed in the same room and were assigned to Nurse Shetty. Patient #1 was a 9-day old female infant admitted to 4NE on November 17, 2007 with a rash. Physician's order was for Acyclovir every 8 hours IV, and Vancomycin every 8 hours IV. Patient #2 was a 9-day old male infant admitted to 4NE on November 17, 2007 with a rash. Physician's order was for Acyclovir every 8 hours IV, and Vancomycin every 8 hours IV.
- 13. On November 18, 2007, shortly after her shift began, Respondent was informed that there was noticeable oozing from both Patients #1 and #2's IV sites. Respondent advised Nurse Shetty to continue to monitor the patients.
- beep, indicating that the medication that was being given was completely infused. Per hosptial protocol, Heparin Flush 10 units per milliliter is to be administered after the administration of IV medications. Respondent turned off the pump and proceeded to the medication room to obtain and prepare a Heparin Flush dose. Respondent obtained a Heparin vial where the Heparin 10 units per milliliter were stored, but did not recall if she verified the correct dosage and expiration of the drug. She prepared the Heparin Flush in a syringe and placed an orange label on the syringe, which was used to identify that it was Heparin Flush as opposed to saline flush. The label did not inloude the patient's name, dosage, concentration amount, date or time. Respondent

advised Nurse Shetty that the patient's medications were completely infused and needed to be flushed. She handed the Heparin Flush syringe to Shetty for administration, and began to prepare another Heparin Flush for the other twin patient. Respondent did not document her preparation of the Heparin Flush anywhere in the hospital records.

15. At about 2115 hours, Respondent was informed that the oozing from Patients #1 and #2's IV sites continued. At 2240 hours, the Heparin drawer was discovered to contain Heparin vials 10,000 units per milliliter. Laboratory tests conducted that day revealed that Patients #1 and #2 were overdosed with Heparin. On November 19, 2007, two doses of a Heparin reversal antidote, Protamine Sulfate 25mg, were administered to both patients.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

- 16. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct as defined under California Code of Regulations, title 16, section 1442, in that on or about November 18, 2007, while on duty as a Charge Nurse at 4NE at CSMC, Respondent was grossly negligent in the following respects:
 - a. Patient #1 or Patient #2. At about 1945 hours, Respondent drew up a Heparin Flush solution into a syringe and could not recall if she had checked the vial for the correct medication, concentration or expiration date. Complainant refers to and incorporates all the allegations contained in paragraphs 12 15, as though set forth fully.
 - b. Patient #1 or Patient #2. At about 1945 hours, Respondent drew up a Heparin Flush solution into a syringe but did not verify the correct medication, concentration, route or absence of discoloration or particulate matter with another nurse who administered the drug. Complainant refers to and incorporates all the allegations contained in paragraphs 12 15, as though set forth fully.

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SECOND CAUSE FOR DISCIPLINE

(Incompetence)

- 17. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct as defined under California Code of Regulations, title 16, sections 1443 and 1443.5, in that on or about November 18, 2007, while on duty as a Charge Nurse at 4NE at CSMC, Respondent was incompetent in the following respects:
 - a. Patient #1. At about 1945 hours, Respondent labeled the syringe only as "Heparin Flush" with an orange sticker without indicating the concentration, patient name or second patient identifier. Complainant refers to and incorporates all the allegations contained in paragraphs 12 15, as though set forth fully.
 - b. Patient #1. At about 1945 hours, Respondent handed the Heparin Flush syringe to another nurse to administer but did not verify the correct medication, concentration, route or absence of discoloration or particulate matter with that nurse. Complainant refers to and incorporates all the allegations contained in paragraphs 12 15, as though set forth fully.
 - c. Patient #1. At about 1945 hours, Respondent failed to document the withdrawal of the Heparin Flush on any hospital records. Complainant refers to and incorporates all the allegations contained in paragraphs 12 15, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

- 18. Respondent is subject to discipline under Code section 2761, subdivision (a) on the grounds of unprofessional conduct, in that on or about November 18, 2007, while on duty as a Charge Nurse at 4NE at CSMC, Respondent committed the following:
 - a. Patient #1. At about 1945 hours, Respondent improperly exhibited an implicit or implied authority over the staff nurse by handing the incorrectly-labeled Heparin Flush syringe to her to administer. Complainant refers to and incorporates all the allegations contained in paragraphs 12 15, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

- 1. Revoking or suspending Registered Nurse License Number 611593, issued to Kristen Noel Voelker;
- Ordering Kristen Noel Voelker to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;
 - 3. Taking such other and further action as deemed necessary and proper.

DATED:	11/3/00	Louis A. Boutley
	''	LOUISE R. BAILEY, M.ED., RN/
		Interim Executive Officer

Board of Registered Nursing Department of Consumer Affairs

State of California Complainant

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